State of California - Health and Human Services Agency | Department of Alcohol and Drug Programs

FORM A

Check here if this is a revised or an amended Invoice /__/

COMPREHENSIVE DRUG COURT IMPLEMENTATION QUARTERLY CLAIM FOR REIMBURSEMENT

Mail Completed Form To:

Department of Alcohol and Drug Programs
Office of Drug Court Programs
1700 K Street, 5th Floor
Sacramento, CA 95814-4022

County:_____ **Grant Award #**_____

Grantee:_____
(County Agency identified as Grantee on the Notice of Grant Award)

Address:_____

City/Zip: _____

Phone: _____

Email Address:_____

Project Budget Period From: ____/____/____ **To:**____/____/____

Billing Period From: ___/___/___ **To:** ___/___/___

Summary of Expended Treatment Related Costs *(Do not Inlcude court related/other costs)*

Section I:	A	B	C
BUDGET LINE ITEMS	**Beginning Balance**	**Current Expense**	**Ending Balance**
Personnel	$ -	$ -	$ -
Fringe Benefits	$ -	$ -	$ -
Other Administration Costs	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Training	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Contractual Services	$ -	$ -	$ -
Indirect Costs	$ -	$ -	$ -
Total of Treatment Related Costs	$ -	$ -	$ -

Summary of Expended Court Related/Other Costs *(Do not include treatment related costs)*

Section II	A	B	C
BUDGET LINE ITEMS	**Beginning Balance**	**Current Expense**	**Ending Balance**
Personnel	$ -	$ -	$ -
Fringe Benefits	$ -	$ -	$ -
Other Administration Costs	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Training	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Contractual Services	$ -	$ -	$ -
Indirect Costs	$ -	$ -	$ -
Total of Court Related/Other costs	$ -	$ -	$ -
GRAND TOTAL **(Includes Treatment and Court/Other Costs)**	$ -	$ -	$ -

I hereby certify that all costs are consistent with the grant award.

X _____ Date:____/____/____ _____

Alcohol and Drug Program Administrator (AOD) **Please print name of AOD**

Please use blue ink for original signature.

Department of Alcohol and Drug Programs Office of Drug Court Programs Use Only

I hereby certify that the required reports for the above billing period have been received.
The fiscal data contained in this invoice has been recorded and submitted to ADP's Accounting

_____ Date:____/____/____ _____

Comprehensive Drug Court Implementation Project Coordinator **Please print name of Coordinator**

ADP Accounting Section Use Only

TC Number:	FY:	Index Code:	PCA Number:
Vendor Number:	Grant:		